Long-Term Care Survey Alert

PATIENT SAFETY: Could This Patient Safety Nightmare Be A Discharge Away?

Failing to reconcile a patient's meds could result in a liability wake-up call.

Picture this: You discharge a resident on the blood thinner warfarin. He goes home and begins to take Coumadin in his medicine chest. Two weeks later, you get a call saying the former resident has had a massive abdominal bleed caused by doubling up on the generic and brand-name versions of the same drug.

The resident's family is on line one and the surveyors are on their way to see whether the staff educated the resident about the dangers of taking his previous prescription medications at home.

That type of scenario can play itself out in almost countless ways in facilities that don't have a standardized process to make sure the resident or his family knows what medications he should take after discharge or during a therapeutic leave.

The Institute for Healthcare Improvement has seen patients show up in the emergency department because they continued to take a medication after discharge from a healthcare setting because no one told them to stop taking it, cautions **Fran Griffin, RRT, MPA,** spokeswoman for the organization. "Patients may assume they should resume all of their medications when they go home," she says. "Or they find old medication in their medication cabinet--and people hate to throw things out."

A patient can end up duplicating medications if he or his caregivers at home--or healthcare providers--aren't familiar with trade and generic names of medications, cautions **May Adra, PharmD**, director of drug information/medication safety coordinator at **Tufts-New England Medical Center**.

Pay attention to these dangerous drugs: In addition to warfarin and Coumadin, make sure residents/families know that digoxin and Lanoxin are the same medication, says Adra. Other commonly prescribed generic and trade-name drugs that patients might accidentally double up after discharge, according to Adra, include:

- Anti-hypertensives, such as lisinopril and Zestril
- Lipid-lowering agents such as atorvastatin and Lipitor

Teach Residents/Families How to Avoid Taking Duplicate Meds

As part of your medication reconciliation process, think through how you will ensure patients take the right medications after discharge.

The **Joint Commission on Accreditation of Healthcare Organizations** recommends facilities give patients a "complete list of medications" that they will be taking after discharge from the facility. Also include "instructions on how and how long to continue taking any newly prescribed medications.

"Encourage the patient to carry the list with him or her and to share [it] with any providers of care, including primary care and specialist physicians, nurses, pharmacists and other caregivers," advises the Joint Commission in its Sentinel Alert on medication reconciliation.

Real-world example: Boston Center for Rehabilitative & Subacute Care teaches the resident/family about his list

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of discharge meds--and how to avoid taking duplicate medications, says **Anne Lavoie, RN, MSN, MBA, VP** of clinical services at **Partners HealthCare,** which operates The Boston Center.

"If the resident will be receiving home health care, the home health nurse will take the list and compare it to what the patient has in his medicine cabinet."

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